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Article

Culture in the Healthcare Industry

Ajay Aggarwal • September 27, 2023

The series of recent high profile cases in the UK national media surrounding healthcare staff's involvement in unsafe delivery of healthcare services has put healthcare culture into the spotlight. When healthcare issues in the UK have previously emerged, inquiries have given rise to a multitude of recommendations to try to prevent such issues arising again.

One of the most comprehensive includes Sir Francis' report on the Public Inquiry of the Mid-Staffordshire NHS Foundation Trust1. In addition, technological advances and research have been conducted in order to improve patient safety, quality and risk management. However, despite these measures, it seems that a fundamental issue linked to cultural environments which exist across the healthcare industry remain a contributing factor to the continuation of unsafe practices.

Healthcare as a high reliability organisation

Gatherings of healthcare risk managers often include a discussion on high reliability organisations (HRO), and recent events highlight the importance of high reliability within a healthcare setting. HROs traditionally include airline industries, NASA, supermarkets and utilities, which commonly implement systems to ensure that they achieve consistency in order to reach their goals and avoid failure2.

Healthcare risk management professionals often look towards these industries for learnings, despite some of their own inherent challenges to achieve HRO. Delivery of safe patient care is delivered by a wide variety of different teams, with differential hierarchies, and a traditional healthcare workforce model. A workforce model proposes the ideal workforce for healthcare as a safety critical HRO. Traditionally, in the face of critical events, the less experienced or junior staff are the first responders, and often make important decisions in the critical safety windows. These staff members then select the work that is escalated to

the experienced workforce.

The critical event has not benefited from the experience of the expert workforce, which may have had an impact on the trajectory of the consequential pathway. A safety critical organisation, would, ideally have the more experienced workforce face the safety critical events from the outset, who would delegate to the junior staff as appropriate. It follows on that this could create an important culture of safety amongst healthcare staff, and improve more general working conditions for staff3.

Just Culture

The Just Culture is another well-known and discussed issue between healthcare risk managers. Defining it can be complex, but notably in the current context, it emphasises both the personal and organisation level of accountability and regulation.

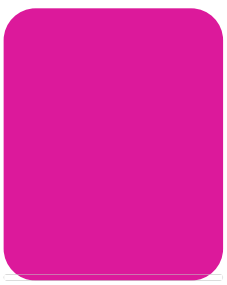
The structure aims to move away from intimidating healthcare personnel and fosters an environment which encourages all healthcare staff to raise concerns. Recent events have highlighted this particular issue and the importance of listening to all healthcare staff concerns. Acting appropriately in each and every circumstance is conducive to fostering a safety culture.

A survey found that healthcare professionals who do not receive feedback when raising concerns can start to disengage in the process4; if professionals no longer feel it is of value to raise concerns, then the culture moves away from the Just Culture and the consequential benefit to patient safety.

Culture remains core to risk management advances

In the face of technological and other safety, quality and risk management advances, cultural practices in healthcare environments remain a major factor in achieving the desired national and system wide improvements.

Risk solutions should continue to focus on the underlying cultural values in healthcare organisations, fostering a safe and effective workforce and allowing specific risk solutions blossom into their full value. Please get in touch if you would like to discuss our international Miscellaneous Medical product.



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References:

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2. Molly Gamble, “5 Traits of High Reliability Organizations: How to Hardwire Each in Your Organization,” April 29, 2013 accessed 3rd September 2023
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